

Appendix 9

Referral Form (Sample Format)

Client's Name: _____ Date of Referral: _____
Medicaid ID Number: _____ Address _____
Birthdate: _____
Telephone Number: _____

Referral To: *[Service provider's name, address, and telephone number]*

Referred By: *[Service provider's name, address, and telephone number]*

Reason for Referral: _____

Authorization: I, _____ *[Client's Name]*, give my permission to _____ *[Service Provider's Name]*, to release this information to _____ *[Care Coordination Provider's Name]*. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of client/parent or guardian: _____

Date: _____

Service Provider's Reply (summary of findings, diagnosis, recommendations, comments, as appropriate):

Signature: _____

Date: _____